The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) U.S. CORE DATA FOR INTEROPERABILITY TASK FORCE 2021 MEETING

February 16, 2021, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Steven Lane	**Sutter Health**	**Co-Chair**
Terrence O'Malley	**Individual**	**Co-Chair**
Ricky Bloomfield	Apple	Member
Hans Buitendijk	Cerner	Member
Grace Cordovano	Enlightening Results	Member
Leslie Kelly Hall	Engaging Patient Strategy	Member
Jim Jirjis	HCA Healthcare	Member
Ken Kawamoto	University of Utah Health	Member
Leslie Lenert	Medical University of South Carolina	Member
Clement McDonald	National Library of Medicine	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Brett Oliver	Baptist Health	Member
Mark Savage	University of California, San Francisco's Center for Digital Health Innovation	Member
Michelle Schreiber	Centers for Medicare and Medicaid Services	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Sheryl Turney	Anthem, Inc.	Member
Daniel Vreeman	RTI International	Member
Denise Webb	Indiana Hemophilia and Thrombosis Center	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Al Taylor	Office of the National Coordinator for Health Information Technology	Staff Lead

Call to Order/Roll Call (00:00:00)

Operator
All lines are now bridged.

Michael Berry
Great, thank you. Good morning, everyone. My name is Mike Berry. I am with ONC's Office of Policy, and I would like to welcome everybody to the USCDI task force. We are going to get started with roll call, and then I will turn it over to our co-chairs. Steven Lane?

Steven Lane
I am here.

Michael Berry
Is Terry O'Malley on? Ricky Bloomfield? Hans Buitendijk?

Hans Buitendijk
I am on. Good morning.

Michael Berry
And, we have a new member to our task force, Grace Cordovano. I know Grace was having audio –

Steven Lane
Mike –

Michael Berry
Yes?

Steven Lane
Correct.

Michael Berry
And, Steven will be introducing Grace after we get started. Leslie Kelly Hall?

Leslie Kelly Hall
Good morning, thank you.

Michael Berry
Jim Jirjis? Ken Kawamoto?

Ken Kawamoto
Good morning.

Michael Berry

Les Lenert? Clem McDonald? I know Aaron Miri is not able to join us today, and neither is Brett Oliver. Mark Savage?

Mark Savage
Good morning.

Michael Berry
Michelle Schreiber?

Michelle Schreiber
Good morning.

Michael Berry
Sasha TerMaat?

Sasha TerMaat
Good morning.

Michael Berry
Andy Truscott? Sheryl Turney?

Sheryl Turney
Good morning.

Michael Berry
Dan Vreeman?

Daniel Vreeman
Hello.

Michael Berry
And finally, Denise Webb.

Denise Webb
Good morning.

Michael Berry
Good morning to all. Okay, thank you, and now I will turn it over to Steven.

Steven Lane
Thank you so much, Mike, and thank you to everyone who was able to join us this morning. A number of folks are dealing with weather issues and other challenges. We have had a – I think we mentioned last time – a resignation from the committee which created a new space within our group, and Grace Cordovano, who has been attending our meetings since the beginning and who a number of members suggested as a helpful voice to join our discussion, has very kindly agreed to join us officially, so this is not her first meeting,

but it is the first one where she has her mic turned on. Grace, do you want to take a second and introduce yourself if you can? Maybe the mic has not made it yet, but Grace is a patient advocate professionally, and I understand she is board certified and active in the patient space, so I think she will bring a helpful voice to our discussion in addition to those we already have.

Grace Cordovano
Good morning.

Steven Lane
There you are. I think you brought a little echo with you, too. Can you try again, Grace?

Grace Cordovano
I think I got it this time. I apologize.

Steven Lane
Perfect. Do you want to introduce yourself briefly?

Grace Cordovano
Yes. Good morning, everyone. I am Grace Cordovano. I am a board-certified patient advocate specializing in the oncology space. My day to day is working with patients and their families from point of diagnosis through survivorship or end-of-life care planning. I help people navigate their diagnosis, predominantly in the oncology space, but as you all know, because someone gets a cancer diagnosis, it does not give them a clean bill of health, so all of the comorbidities and social determinants of health come along for the ride. So, I essentially help people navigate their diagnosis as well as the fragmentation that is our healthcare system, and as you all may know, a lot of that is rooted in having actionable, seamless, successful access to their health information throughout their care journey. I am absolutely thrilled to be here. Thanks for having me.

Past Meeting Notes (00:04:09)

Steven Lane
Great. Thank you so much, Grace. Also, Terry O'Malley – just looking at our list – still has not had a chance to join us. Terry has told us that he has had some issues come up in his personal life that are going to prevent him from continuing to participate in our task force, unfortunately, and he was going to try to come this morning to let you all know that himself, but that obviously has not happened so far. If he does, we will give him a moment, but suffice to say that we are going to be seeking out another co-chair.

We do have a candidate from amongst our membership who is also a member of the HITAC. I think we would like the co-chair to be from the HITAC. I do not think it is an absolute requirement. I recall being on FACA task forces in the past where one of the co-chairs was not a HITAC member, but be that as it may, any of you who are particularly interested in the potential opportunity to help co-chair this task force as we move forward over the course of the year, please let us know, and we will be trying to sort that out between now and the next meeting. All right. So, in terms of our meeting notes, I believe we completed the notes from our first, but not our second meeting. Is that right, Mike?

Michael Berry

Right.

Steven Lane
And, those have been posted to the website. Is that correct?

Michael Berry
I believe so. I will check with Katie. Katie, have those been posted yet – the first week's meeting notes – to the portal or the website?

Accel Solutions LLC
Yes.

Steven Lane
Wonderful. So, I think our plan is to – we have three rounds of review on those before we put them up, and they will be put on the website. Katie, it does not seem like we have a specific plan to let people know when the meeting notes have been posted. We could do that if people felt strongly about it, I imagine, but that is where they are going to be. We are going to try to turn them around as quickly as possible so people ideally would have a chance to review the notes from the prior meeting before the current meeting – especially for those who cannot make it, I know that is very helpful – so that will be our goal, and we will see how we do with that, but I do not think we were planning to do a formal approval of the minutes. We are planning to simply get them up there and let you know that they are there. Do you have that right, Mike?

Michael Berry
Yes, Steven, you got that right.

Task Force Charges (00:06:47)

Steven Lane
Perfect. Okay, very good. So, let us jump in with both feet to our work. Let us go ahead to Slide 3, just reviewing our task force charges for everyone who is here. Also, I want to specifically welcome the members of the public who have joined our meeting. We see a number of folks here. I want to actually thank Shelly Spiro, who provided us some public comment at a recent meeting. That is a great way to get your comments into the public record, and Shelly, we thank you for that. Any of you who are members of the public and attend this meeting are welcome to provide public comments toward the end of the meeting. We very much appreciate that.

Also, before we jump in here, I want to remind folks that with the help of Andy Truscott, the co-chairs made a number of specific outreaches to members of the community and asked them to provide us with early input regarding the USCDI Version 2. A number of people have come forward with that, and in working with our colleagues at ONC, we have learned that really, that input – we could not just forward it to people or post it on a Google Drive. It needs to be made part of the public record for us to share it with folks, so people who sent those have been invited to enter them as comments directly on the website.

I am looking at Dan's smiling face here this morning, and I think Dan mentioned to us last time that he had prepared some comments, and he was successful in uploading those to the website. Mark also did the same, and a number of other folks – our friends from Kaiser – recently provided some very helpful input,

and I think just this morning, they uploaded that to the website. So, as you are doing your review of the draft Version 2 and of the individual data classes and data elements, please go to the website, scroll down to the bottom of each of the pages, and look for those comments because that is where those are being placed. Dan, did you want to add anything to that?

Daniel Vreeman
No – well, yes, one thing. In my own opinion, it is nicer when the comments are in line with the data class and the data element as opposed to being blanket at the top of the page, which you can do if you have a whole bunch of things to say, but as we are reviewing, it is nice if we can just pull up that collection and see the specific ones there. If you are so inclined to go to that extra effort, I always find it helpful.

USCDI TF Recommendations Document (00:09:34)

Steven Lane
I agree, I think it is nice. I think I mentioned last time that I have had a chance to put in some individual comments, and we invite you all to do that as you see fit. All right. So, with no further ado, and with thanks to those of you who have acknowledged your presence in the public chat – Jim, Clem, Ricky – thank you for joining us. So, this is, again, our charge. We have enumerated the various charges.

You will all recall that we pretty much have had our way with Charge 1A, looking at data classes and elements from USCDI Version 1 and the applicable standards version updates that have been proposed by ONC. If people have additional comments that arise that they want to bring forward there, I think we can certainly discuss those here. Dan, I know some of your comments did have to do with Version 1 data elements and classes, and those have been added to the website. So, we are hoping today to dig into Task 1B, which is to say the new data classes and elements from the draft Version 2 and the applicable standards that have been attached to those, recalling that thereafter, we are going to focus in on 1C, the Level 2 data classes, the proposed data classes and elements that were leveled as Level 2, but not included in draft USCDI Version 2.

I will point out that I think a lot of the people who have attended these meetings and have spoken up have been focused on the notion that the draft V.2 is very skinny and does not include a lot of news compared to Version 1. I will point out that some of the public comment that we have received in response to outreach says just the opposite. It says it is really good that we kept that so small, that the industry, vendors, and providers are really not in a mood to take on a lot more, so it is good to have a diversity of voices covering that material.

Let us go to the next slide, Slide 4 in the deck that was distributed. This is a representation of a Google Sheets doc – or, maybe it is an Excel doc, I cannot remember, but it has been posted on the Google Drive for all of the members of the task force, and the idea here is that we are going to use this for record keeping as we go through and have our discussions. A number of people have made specific points about changes that they would like to see made and the reasons and justifications for those changes. What we would like to do is to start to capture those in this document. Everybody who is on the task force should have been asked to forward whatever email you use to access documents on Google Drive, and you should have been granted access to this document on the drive. Katie or others from Accel, can you comment on how well we are doing getting people access to the document?

Accel Solutions LLC
Yes, this is Katie. I think we have a bit over half of the members, but if anyone has not replied with their Gmail account, they can just send it to me, and I can give you access.

Steven Lane
And, I think the access we are granting is edit access. Is that true?

Accel Solutions LLC
It is commenter access.

Steven Lane
Comment access, okay. So, at this point, then, that means that our plan is that the ONC team and the co-chairs – or, co-chair, at the moment – will be adding information to this, and we will give people the opportunity to add comments. Again, what we want to do is without making this just a craziness of too many cooks in the kitchen, we do want to capture people's input, use this to build a listing of our key findings as we go along, and use that later on in the year when we construct our feedback to the HITAC and ONC. Any questions about that? Jim said, "What email do I send the email to?" Do you want to respond to that, Katie?

Accel Solutions LLC
Yes. I am just typing it in the chat now.

Tasks 1a and 1b (00:14:22)

Steven Lane
Okay, perfect. All right, good. Any other questions about that? I do not see any hands raised or any comments. We will move ahead. All right, so, the next slide, Slide 5, is going to become familiar to everybody. This is the draft USCDI Version 2, showing all the data elements and classes that were in Version 1 plus the additions and changes that have been brought forward for Version 2, and unless somebody has a better suggestion, I think the best way to approach this will probably be to simply take these in order, so let us make sure that we have covered – okay, let us hop down to – actually, before we take them in order, let us start with the reclassifications. Again, I think we covered this last time, but I just want to make sure that there are not any residual comments, so hop to Slide 7.

All right. So, this describes the movement – the reclassification of three specific types of clinical notes into two new data classes for diagnostic imaging and laboratory, and we move the notes over. Clem led us in a lively discussion last time about potential redundancy in these. Dan, I think some of your comments also spoke to some of the challenges of these, and I would really invite people to go read Dan's comments. They are quite thoughtful. Dan, I think we lost you before you covered this last time. I actually cannot remember whether you covered this particular piece last time. Did you want to add anything based on your thoughts?

Daniel Vreeman
I made comments both about the laboratory report narrative and the path report narrative, not about the organization or the movement per se, but putting – now, in this new context, there are a couple of issues that come to mind. The first is related to the laboratory report, and this is probably likely part of what Clem discussed earlier – how this relates to the result values and not being anchored to whether this is an entire

report with multiple observations, a conclusion, or an interpretation. There is no clarity on that, and in many ways, it might just be redundant if it is meant to be things that are reported as narrative that show up as OBS 5 or an observation without a value.

The second is the language around pathology reports. I tried to write this up – I think we should think a little bit more precisely about how we label that. The addition of narrative in this context is a little confusing because path reports typically take three structures. They vary in narrative to structure to this fully synoptic category, and I have linked to some references that describe that more completely, and by the use of the word "narrative" here, we might be miscuing some people that only that subset of those – i.e., those that are like free text – are meant when I think what we really mean is that entire scope of data regardless of its underlying structural representation.

Steven Lane
Yeah, and my sense personally – and, I will ask Al to comment – is that the context here is that we want not only quantitative discrete data fields, but we also want to capture the narrative. We do not want to lose any of it, whether we are talking about lab, path, or imaging, and I think that is the spirit of these data elements, but I think you make such a good point, Dan, which is that when you get down to the actual programming – what does that mean, what segment of the message does it go in with what part of the report does it go in, and what exactly is being requested? Al, maybe you can comment because we have certainly seen a number of commenters make note of some lack of absolute clarity on these.

Al Taylor
Sure. I think the most important thing that we want to convey is that by moving – understanding that each of these three data elements could very easily be part of the diagnostic imaging report or the lab report, and that both of those elements have narrative components in them already, but we did not fully define in USCDI what a lab report or a diagnostic imaging report should contain or how it should be structured, and so, what we did not want to do is have the capability to capture or exchange a diagnostic imaging report that does not have any narrative components to it, has only structured data elements, and still qualifies as a diagnostic imaging report.

So, our original intent with adding clinical notes was to be able to capture the rich narrative that accompanies any of these clinical note types, and that simply reclassifying did not change the fact that we still want narrative components of lab, path, and diagnostic imaging to be able to be captured and exchanged. So, I hear loud and clear the valid comments that perhaps these are duplicated, but we did not want to lose the concept that we want narrative in all of these categories to be able to be shared.

Clement McDonald
This is Clem. Can you hear me? Am I on voice?

Steven Lane
Yes, Clem. Go ahead.

Clement McDonald
I would like to weigh in. I think this could be a disaster for confusing the whole world, and they apply differently to different ones. So, laboratory reports are typically structured, but one of the structures might

be final impression, and that would be text, so that creates confusion. The bigger problem is that this will give an opportunity to every company that does not want to worry about structure and coding to use a single code and send all lab reports as one glob, which will destroy all the progress we have made over the last 15 years. So, I think it could really be bad because you have one code for laboratory narrative, and a lot of places would likely just send blobs of text, and so, we really ought to change this radically, and maybe just highlight that reports could be pure narrative or not, but use the standard codes, whichever you use for the ordering test – either way.

So, in radiology or in imaging, it is almost worse – well, it is different because in imaging, they are almost never structured. They are nice narrative things that are coherent. Sometimes, they will be broken into separate sections – separate sub-records for the impression and description, et cetera. But, those will have a different confusion because people will go, "Well, I guess I have to wait for a structured one before I use any of the specific codes for chest x-ray, lung CT, or any of those things, and I will just use this one single code," which, again, will make it harder for receivers to use the data. So, I think it has to be totally rethought, and there are double and triple confusions in it.

Steven Lane
So, Clem, what I think you are saying is that we need to make sure that we clarify in USCDI Version 2 just what is meant here, that the narrative – whether we are talking about lab or path – is in addition to the discrete data elements, not as an alternative to those, and I think if we do that well, we should be okay without having to "rethink" the whole thing.

Clement McDonald
Well, I do not know about that because you have given a single LOINC code, which suggests an overarching thing that is going to get sent as one unit. It does not really admit or acknowledge the parts – the fact that some pieces are narrative and some are structured – any of that. I think it is going to be a big step backward unless it is restated completely differently.

Steven Lane
Perfect, Clem.

Al Taylor
Clem, I appreciate the comments, and I hear your concern about the possible confusion in having both lab report and lab report narrative, and the same thing for diagnostic imaging. We have not gotten rid of the idea that we want a separate – that we want a diagnostic imaging complete report, whether that is structured, unstructured, or a combination, but I think there might be some room to improve the definitions for each of the narrative elements and the report elements to be clear that if we decide to combine them, then we want to make sure that the laboratory report at least has the capability of conveying narrative as well.

Clement McDonald
No, I think that is a good idea, and I think that can be done by a comment rather than making a whole new thing. Just explain it. Anyway, I understand –

Steven Lane

Grace has her hand up. Do you want to jump in, Grace?

Grace Cordovano
Yes, thank you. In catching up here – and, I apologize if this has been covered in the past – I am still struggling with trying to understand the report and narrative. One of my comments from a big picture is when I reviewed this Draft 2 and you start going through the data classes and elements, there is no real-world example to demonstrate and illustrate what these elements and classes may look like in the real world. My one comment would be is there a way to use synthetic data to show snapshots? Because someone new walking in or someone from the public may not have the privilege of the understanding of all of these spaces, and that ties in with my question on when you are talking about report and narrative, where is this narrative that is being referred to? Can you give me an example or illustrate in a screen share where this would appear? I have been doing this for quite some time, and I have never seen "narrative" called out. It is usually "impression" or "findings."

Steven Lane
Thanks. Hans?

Hans Buitendijk
Thank you. I want to expand a little bit more on what Clem indicated on the separation or the combination of narrative and the report. I think by having introduced it as a separate notion, it increases the risk that people are going to think of it as different, so I would certainly encourage us to look at it as a report, then clarify within that data element or that concept that there are narrative impressions, structure, and coding – that those aspects are in there, and that what we are looking for is for that to have a good balance, to be properly reflected, and does not have any absent narrative where there should be one. Just mentioning them and listing them separately will have people interpret them as "I have to do something else" as well as "I need to create a better report."

Steven Lane
Thank you, Hans, and I think we are covering some material that we also discussed last week, so let us look for some new insights because poor Al has heard this loud and clear at this point. Ricky, do you want to add?

Ricky Bloomfield
Yeah. I made a comment in the chat as well. At a high level, typically, this level of granularity in terms of guidance would come in the implementation guide development process, and so, I am wondering if we believe that our guidance to ONC for the USCDI should have this level of granularity, which typically has not existed within the USCDI before, or if we should share that with HL7 to be included in additional guidance within US Core. It seems like it is a little bit of a change in how USCDI has been perceived thus far, and I want to make sure we are providing the most effective guidance, and if we do decide to include this level of granularity in USCDI, I think that is great, but we need to decide where that feedback goes.

Steven Lane
And, Ricky, you said to include it in US Core, but also presumably in CDA and as needed in V.2, right? It is not just for FHIR.

Ricky Bloomfield
Sure, wherever it is applicable.

Steven Lane
All right. Dan, your hand is up.

Daniel Vreeman
I was going to say I agree with Hans. I second that. Second, I want to emphasize Clem's point in that the way these are referred to in USCDI today suggests that a single code could be used across all diagnostic imaging reports – there it is – for lab reports and path reports. We absolutely do not want that. We want the more precise coding for each of the specific things that are done, and so, I want to double emphasize that I am with him on that.

Steven Lane
Perfect. And, Leslie, you found the hand-raising function. Go.

Leslie Kelly Hall
Yeah, I would just say that if we take the precedent of establishing new standards here, we are bypassing processes that already exist and already vet in significant ways, and so, I think this is not the place to be doing this. Furthermore, the problem that was stated that we are trying to solve is the fact that these reports were so large. Breaking them up in a way that could create unintended consequences by having the context separate from the narrative is not responsible as well, and I think the fact that we are all confused and concerned and that we live this is an example of how confusing this could be to the industry.

Steven Lane
So, to bring this to a bit of a close – Grace, I had not seen that hand-clapping feature, that is very cute – I think that what we should do is come up with some draft language that might become a part of our report back to HITAC that tries to capture what it is we are trying to say here. Any of us could draft that. For some reason, it sort of feels like Hans and Ricky really have a good handle on this because of their deep involvement in HL7, so I do not know if you guys want to take a stab at how to characterize or summarize what it is we are trying to say. If not, you can leave it to me and Al to tinker with, but I think if one of you guys want to put together at least a short paragraph or a few sentences that capture that, I would certainly appreciate that if you were willing. And then, what we can do is put it into the Google Drive doc – the Google Excel file – and then, people can comment from there. Would that be okay? I do not mean to leave anybody out, but Hans and Ricky, can you guys take a stab at that?

Hans Buitendijk
I am happy to work with Ricky on that.

Clement McDonald
I would be happy to help too if you need me.

Steven Lane
I just wanted to keep it simple, that was all. I think if a couple people just put something together and then we get it into the Drive, we can comment from there.

Ricky Bloomfield
I think what would be useful there would be to get all of the notes to make sure we are including all the perspectives that were shared today, and if we can get a summary of those comments, we can use that to draft something, and again, if there is an open way to do this, such as an open Google Doc where everyone can see this draft, edit, and comment, that would be really useful so we have a collaborative approach that is open, and then, anyone who wants to weigh in can do that. I think that would be great.

Steven Lane
It will be open to all task force members initially, Ricky.

Ricky Bloomfield
Exactly. That would be great.

Steven Lane
Yeah, that is the plan. Perfect. I am trying to keep up with the comments here. Leslie, I think you had a chance. Ken had to leave. Denise: "The SNF community is not clear on how USCDI applies to them since they do not use certified health IT for the most part." Good point. All right, good. So, anything else on the reclassification? Again, I think we have covered that well, both last week and this. All right, very good. Then, let us move back – oh, was there anything else – pop up to Slide 6 for just a moment – was there anything else that had come to people's minds related to USCDI Version 1 data classes, elements, or standards that people wanted to resurface before we consider that one complete? Again, it is a little unfair because you cannot read the notes from our prior meetings and we have not pulled forward the tasks into our spreadsheet, so we will do all of that, but did anyone have any further thoughts on Version 1? Sorry, we are trying to get into a rhythm, as we have members dropping away, so we are doing the best we can.

All right, then. Let us hop to Slide 9, where we will focus in on our Charge 1B, new data classes and elements – not the ones that were just moved, but the new ones that were suggested for draft Version 2 and their applicable standards. So now, if you go to Slide 10, you have the short list – notably short – of new elements that have been proposed. All of you hopefully have had a chance to go onto the website and dig into these, looking at the applicable standards and the comments that have been collected to date. Dan, I think you did have a comment specific to care team members, and maybe that would be a good place to kick off the discussion, but let us focus first on care team members. I think we have had our way with diagnostic imaging, but there may be more on that, and then we will eventually get to encounters and problems. So, care team members – Dan?

Daniel Vreeman
Thanks. So, "care team members" is both a data class and a specific data element, and the new things that were added were two data elements, one for provider name and another for provider identifier. My concern initially is simply that the significance of labeling these two data elements as being providers has real overlapping meaning with the thing that already existed, which was care team members. It strikes me that we could simplify by simply having two data elements, "care team member name" and "care team member identifier." The significance of labeling something as "provider" has a number of different implications – regulatory definitions and so forth – and I do not think we necessarily need to do that.

Specifically on the idea of an identifier, I think it is great. I think we should consider that as something that would be a must-support, meaning send it if you have it, but recognize that not in every instance will a person who is a care team member have an identifier such as an NPI, so it should not be mandatorily required in the sense that it needs to always be present, but if and when there is an appropriate identifier such as the NPI, it is obviously extraordinarily helpful. So, in that regard, those are my two comments, but I think focusing in on the redundancy or overlap between this thing called "care team members" and now these two things would be an important issue for us to resolve and comment on.

Steven Lane
Great. Thank you, Dan. We have lots of hands up. Leslie?

Leslie Kelly Hall
Yes. I think the description that you just gave, Dan, assumes a medical model for a care team member, and as you mentioned, we have crossover providers. There are many of them, and they may not have an NPI number. We also have a crossover with care team members that are patients and their family members – their extended care team – which becomes more and more important as we move more care to the home. So, I think we need to look at those care team members and perhaps the "patient demographic" or "provider" fields and reconcile, rationalize, and include a broader definition. I see that there is nowhere in here, for instance, even in our patient demographic, that talks about power of attorney and care team members who have that, and when we originally envisioned this way back when, "care team member" was a holistic definition and not just a medical model, and that should be accommodated in this design.

Clement McDonald
Can I just clarify on that point, or are there hands up?

Steven Lane
There are hands up, Clem, but go ahead.

Clement McDonald
The NPI is not restricted to medical people. Taxi drivers – in fact, anybody can apply for one. So, just to clarify that, it is not intended – it is the only one around that is a national ID. As I understand it, you can actually get a lot of people connected to it, and it does not have to be a physician, a medical person, or a licensed person, and it does not have to be somebody who bills to Medicare. You can apply for an NPI if you want one. So, the point is if you want to have an ID, I do not know another one that you can be, but Dan's point is that you do not have to have an ID. You can put in a name, which is maybe the best you can do short of an ID, but it is not intended to exclude or to focus on the medical model.

Leslie Kelly Hall
When you say "NPI," you do not mean "National Provider ID," you mean any ID that meets a certain NIST standard of identity proofing?

Clement McDonald
No, I do. I mean "National Provider ID." The word "provider" gives it a bias, but in truth, it is not restricted to anybody who is a provider. Joe Blow can sign up for an NPI, and a lot of unusual people do already, mostly

because they bill to Medicare. If you can have an ID, you have a big problem of creating one for everybody. Maybe people can use their Social Security number, but they are not going to want to do that.

Steven Lane

Let me jump in here, if I may, and just point out to folks that when you look at the tab on the website – and, I would encourage all of you to pull that up in the background if you can on another screen or something – and look at the Level 2 tab, you see a lot more detail that has been suggested for the data class of "care team member." So, today, in Version 1, it is just "care team member." I think there probably is some lack of clarity there as to who or how much information, et cetera. I put in a comment that there has been a lot of concern from hospital nurses about showing their last name. I think there is some opportunity to clarify what are the details related to the data class. Within the data elements, in draft Version 2, they have added "name" and "identifier," just generically – any old identifier. Give us an identifier. If you have it, we will take it. That is great.

When you look at the tab for Level 2, you see that they have specifically suggested DEA number for providers – provider location, provider NPI, provider role, which I think really gets at some of the issues that Leslie was raising, and then, provider's telecommunication information – telephone, email address, et cetera. So, I think those are all going to really flesh this out. Those have not been included in draft Version 2. Draft Version 2 really takes it a very small step forward, adding the name and an identifier if you have it. I personally think that having an identifier without telling you what type of identifier it is – whether a DEA, NPI, or an email address – could be more confusing than helpful because then, systems will build an identifier for Version 2, and then they are hopefully going to have to go back for Version 3 and flesh out all the details related to that.

But, again, we want to evaluate the items in draft Version 2 in the context of the other items that have been proposed. I notice there is nothing for care team members in Level 1, and I do see in the comment level that there was the addition of a data element called "data steward." I see a lot of hands up. Denise, if you can bear with me, I want to take a second to let Al speak up because again, Al is the one whose name is on these new data elements as the submitter within draft Version 2, so Al, do you want to speak to what you were thinking?

Al Taylor

Sure. So, thanks for the reminder that I was the one who submitted those. The reason I submitted those was because they – I added a number of different data elements that were already part of various certification criteria, but did not have a place in USCDI, and we talked about the priorities for adding elements to USCDI, one of them being gaps in concepts in Version 1. So, those provider data elements that were added are those that are required by other certification criteria. You are also required by other major reporting programs – CMS requires a lot of provider data in particular – so those data elements were data elements that came out of other certification criteria, and if you drill down into each of them, you can see an original source, and off the top of my head, I do not recall whether it is part of CDA or US Core as far as support goes. Grace, I think you made the point about it being medical-model-centric, and to one extent, for the particular purpose of adding the provider data elements to USCDI, I think you are right. It is medical-model-centric because that is the use case it was meant to serve.

I think the idea that Dan brought up, though, about at least considering a data element called "care team member name," "care team member identifier," and even potentially "care team member role," which is a Level 2 data element – it is an interesting idea, and I think it would make a great recommendation from the task force. I did want to say, though, that the reason the provider data elements were put into the care team member class was because providers are obviously part of the care team. They are not the entirety of the care team, but it made sense rather than creating a new data class, which might cause more confusion and might require possibly duplicate data elements across classes. So, having a care team member name and a provider name in two different data classes did not seem to me to be efficient.

Steven Lane
Thanks, Al. I think you put out on the table a very discreet potential suggestion that we may want to consider, which is bringing "care team member role" from Level 2 into draft V.2, which I think would provide a dimension of context to address some of the concerns that folks have raised. Denise, you are next in line.

Denise Webb
Thanks. Relative to the care team members and the discussion that has been going on, I think to the general public and patients, there is a lot of confusion about what the USCDI means. Does it mean that if a data element is in the USCDI, then as a patient, I can request that data electronically and receive it? Well, it is much more complicated than that because if you think about it, the USCDI really applies to the products of vendors who are part of the certification program, so if these data elements are in the USCDI, the vendor of certified health IT must support the collection, use, and exchange of this data and demonstrate that in real-world testing. It does not mean that the organization that implements that particular certified health IT necessarily has to collect the data unless the data is required by some other federal program, such as CMS, through some of their reporting programs.

So, I think in general, for the public – and even for some provider organizations – in a number of CIOs I have talked to, there is some confusion around what it means if a data element lands in the USCDI. So, I want to just add that there are many individuals that document in the medical record beyond the physician, and as has been pointed out, there are individuals who do not have NPI numbers. I was not aware until Clem mentioned it that you can get an NPI number if you are not a licensed practitioner. But, I think we need to have clarity around the fact that there is more than just the physician or licensed practitioners that is part of the care team, and I endorse the idea of recommending having a care team member name, care team member identifier, and then adding the role.

Steven Lane
Great. Thank you, Denise. Michelle?

Michelle Schreiber
Thanks. So, under "care team member," I would support the type of provider ID because I think it is going to get very confusing, and there are a couple of other things to consider. I do not know if we are thinking of specialty or the type of staff. In the long run, it is very useful to be able to know what specialty or type of staff is used because just to support the person before me, there are many different kinds of providers. There are panel managers, nurse coordinators, and teams that are not here – like tumor boards, for example – that are weighing in as a multidisciplinary group to take care of a patient. I am concerned we are not identifying them, and they are the folks that are actually essential in taking care of a patient. So, at a

minimum, the type of provider identifier and maybe considering the specialty or team. Finally – and, I do not quite know where this belongs, but there is the care team member, and there is also the facility in which a patient is getting cared for, so we need some kind of organization ID. Maybe it is the care team or another category, but some sort of a facility or organization ID. Thanks.

Steven Lane
Thanks, Michelle, and that has certainly come up in our organization as we are approaching compliance with the CMS ADT notification rule and trying to figure out how you actually document care team members when they are, as you say, teams, clinics, or facilities. What is striking is you said – I think you said the type of provider ID. Is that right? So, we have provider name and provider identifier, but Al, it is not clear to me without reading the whole thing – and, I do not think it is there – that it says what type of identifier it is. You include in Level 2 NPI and DEA, so there are specific identifier types mentioned in Level 2, but not this notion of "Here is the provider identifier and here is the type of identifier that it is." Is that something that was considered? That is a question for Al.

Al Taylor
I was finding the unmute button. So, we considered both ends of it. One is very specific. If we are talking about the medical model provider, we are talking about NPI as the identifier that everybody – DEA can be helpful, but the NPI is more universal for providers in the medical model, but we recognize that we potentially wanted to have other types of identifier, whether it is a unique care organization, someone else involved with the care of the patient, or potentially the patient themself, although I do not necessarily see – and, I could be wrong – a patient having an identifier or a family member having an identifier per se, but we wanted to leave it a little bit broader, so the question is whether the requirement for that particular element includes that it is inherent that if you have a particular number or alphanumeric that is that NPI or any other identifier.

Does it make sense that you would have to say what kind of alphanumeric string this is and say it is actually the NPI versus some other number, like a TIN for a community care organization, food bank, or something like that. It could potentially be a different identifier type. To me, it seems like it is inherent to the particular kind of identifier that is used. That may be a false assumption.

Steven Lane
So, Al, I think I sent you an email separately. In the listing for the provider role, you call out two applicable standards. One focuses on HL7's NPI, and the other is a provider taxonomy from NUCC, and that second link is still not working for me, and I think I mentioned that to you in an email. It would be good to refresh that so that we can see what we are thinking about with regard to provider taxonomy because I think as we move toward the idea of suggesting inclusion of care team member role, it will be good to know what that is bound to.

Al Taylor
I will take that one as an item. I have had problems with the NPI link to HL7 identifier value set before, and I will get that fixed, but the NPI number is an element of provider or practitioner – I think "practitioner" is a US Core resource, but it is an element or constraint on one of the attributes under "practitioner."

Steven Lane

Great. Before we go on with the raised hands, which are Hans and Clem, I have been told that Terry has joined us, and I wanted to pause for a minute and hand Terry the mic and give him a chance to say something.

Terrence O'Malley
Great. Thanks, Steven. Good morning, everyone. I wish it were better and different circumstances, but I am calling in to say that I am going to be stepping down from USCDI, and I will sorely miss working with all of you. This has been a great adventure, and it is only getting better, especially with the addition of the new folks on the task force, and I just want to thank you all for all the effort you are putting in. I think it is really a critical task, and one that will shape interoperability for years to come. I especially wanted to call out the work that Al Taylor has done on all of this. It has been truly remarkable to take the concept of ONDEC and the USCDI promotion process and actually make it work. It was just a remarkable job. Again, my best wishes to all of you, and thank you for stepping in. I wish I could join you on this voyage, but you are in good hands. Captain Lane will steer the ship quite well, and Steven has my appreciation for stepping in and doing all this. Thanks, everyone, and best wishes.

Steven Lane
Thank you, Terry. There are a number of people coming in on the public chat, which I do not think you can see – I think you are on audio only – but a number of people are expressing their thanks and best wishes. I want to tell those of you who are new to this that Terry and Christina Caraballo co-chaired the first two iterations of the USCDI task force with aplomb and alacrity, and really did a wonderful job getting us to where we are today where we have a draft V.2, we had a process of getting here, and we are going to continue to evolve that. So, Terry, your work has been most appreciated, and has really helped to move the industry forward. We cannot thank you enough.

Terrence O'Malley
Thank you all, and again, best wishes. Thanks, Steven.

Steven Lane
Sure. All right, I know you have important stuff to get to, so stay with us as long as you feel able, but Godspeed. All right, let us jump back in. So, we are developing some ideas around care team members and capturing that identifier, potentially adding in roles, and potentially, if needed – and, I am not sure if it is needed, but to me, intuitively, it seems that it is needed, but if there is an identifier, there should be a supplementary field to say what kind of identifier it is and not just assume based on its string characteristics that it is an NPI or something else. Other thoughts about that specific to care team members? Sorry, Hans and Clem do have their hands up, so let us go to Hans. Hans, actually, within your comments, I would love it if you could also put on your Cerner hat for a little bit and speak as an EHR developer about what the lift would be to add these additional data elements in the timeframe and constraints related to a new version of USCDI? I think if we and/or the public come forward and say, "No, you really should take this thing that was leveled as 2 and bring it into draft Version 2," obviously, providers and health IT developers will need to support that and accommodate those changes. So, go ahead, Hans.

Hans Buitendijk
Yeah, and I think my comment ties a little bit to that. I get the sense that with the discussion around care team members, what to add and what not to add, if we should have identifier types or not – the question

comes as what is really the purpose of the USCDI? When I contrast it with the FHIR, US Core, and CCDA specifications already there, to a greater or lesser extent, have a number of these fields that say you must support it either literally or that the cardinality is already won and you have to be able to populate it. So, to what extent – what is really the purpose in that regard to adding provider identifier or provider name if you already know that in the US Core and CCDA, you need to have the name of the care team member, you need to have an identifier, and as you drill down further, you need to have a role. There are already identifier types defined in the work that is going on.

In the US Core right now, the patient is part of the member, the practitioner is, the organization is, and in the next version that is being worked on right now, there are a couple other ones being added to that that you can support. Some of them you must, and other ones not. So, what are we really trying to do here? Are we trying to lead ahead of the standards to indicate that this where we need to grow to or reflect it? And, if it is reflecting, are we trying to stay in sync with it a little bit more? Then, we could consider a couple other things. To your question, then, as to what would be the uptake of that, in light of what is already being developed in that context for CCDA and US Core, where we are referencing things that are already in the certified references or in the references to certified capabilities and standards, that is already part of the plans for those that are going to be certified.

So, as an example, if we were to want to add role to the care team members or we wanted to be specific about the identifier being NPI on a practitioner, that is already actually there, so for anybody building out for that, it is not extra work in the sense that it is new scope. It is work if it is not there yet, but it is part of what is already there. So, to me, I am a little bit challenged on what to suggest and what not to suggest to put into USCDI. Are we trying to catch up with some of the standards that are out there that are supporting it, or are we trying to start to get a little bit ahead of it in light of where we are trying to be? So, I have a much more basic question that has started to come up.

Steven Lane
Hans, I will take a stab and then let Al give you the real answer. My sense is that we are reflecting the standards, that USCDI is meant to contain those elements that are well established, that have identified standards insofar as possible that the vendors and transport mechanisms have been shown to support, and USCDI really raises that floor of what everybody is expected to be able to access, exchange, and use, and it is pointed to by things like information blocking, CMS requirements on payers, and potentially TEFCA, so my sense of it is it really is more of a following, but Al, maybe you can clarify further.

Al Taylor
Yeah, it is not – I agree that it is not necessarily that it is following in lockstep with what is evolving in US Core or in CCDA. As you know, there are about six different certification criteria that leverage US Core or CCDA, but those are not the only… Just the use cases that are in certification are not the only ones for the use of USCDI or its predecessor, CCDS. Other programs, including programs that do not or are not required to use certified technology are using USCDI as a reference, and so, it does not – so, we are trying to be mindful that we want to serve as – we are not going to solve every use – we are not going to address every single use case with a new data element in USCDI because that means that everybody has to do it, not just the people that are implementing US Core through certified technology. When other organizations or other programs reference USCDI, they would have to – the users of that particular program would also

have to use an expanded set **[inaudible] [01:02:18]**, which is why we are trying to be modest in our step because it is not only to address the capabilities of certified technology.

Hans Buitendijk
That last part is very helpful to understand because I know for myself and others that I have been talking to, we are comparing primarily between USCDI and either US Core or CCDA because that is what we are focusing on to enable, but your perspective helps us understand why, at times, it may not suggest something that is actually in those standards, but might be too big a step if there are other programs that do not need to follow those standards and need to start to have an uptake. I appreciate that. It is very helpful.

Steven Lane
Clem, you have had your hand up for a while.

Clement McDonald
I was just going to try to simplify. So, the issue about having an identifier – in 20-25 years of HL7 and most other standards, you have to have at least a code and what code system, so you can accommodate anything if you want, but there are two caveats. If you get into standard codes, it is relatively easy, but if you get into hospital-based specific ones, then you have to have these specialized IDs saying which system's code it is, but you can do it. So, there is no reason to limit the codes severely, and in some circumstances, you may not want them to be universal because of privacy for the provider, like a nurse who does not want her last name told. But, there is no problem. You just have to have at least two parts if you want to have an identifier, so do not forget that part. I think Hans said that earlier, too.

Steven Lane
Yeah, I think we have heard provider ID type, and again, as far as I can tell, that has not been called out as a data element in and of itself, and Al, I do not necessarily want to put you on the spot, but did you think that "provider ID type" was subsumed under "provider ID" when you added that to the draft V.2, or did you think that was a missing element?

Clement McDonald
Just to clarify, in the standards world, that is usually considered a coding system ID, not a provider type ID.

Steven Lane
Okay, coding system ID. I assume that is also the version – you have to know the system and the version.

Clement McDonald
Correct, and that is pretty standard in the various standards systems. If you have a code, you have to have this other piece. ICD-9 to ICD-10 was a disaster because – well, ICD-8 to ICD-9 – because no one knew which one it was for that interim period, so from then on, everybody said you had to have an identifier for what the coding system was.

Steven Lane
So, Al, back to you. Do you consider that to already be subsumed under the provider ID data element that we have listed in draft USCDI Version 2, and/or do we need to specify that more clearly?

Al Taylor
So, the function was subsumed, but I understand Clem's point that the identifier is the string that is unique to the provider, but you need to understand that the identifier type, not the provider type, is a whole different ballgame. The identifier type is the code system or the program system that produces that string. So, I think it is a fair point to take a look at whether or not USCDI itself has to solve it as opposed to solving it in other parts of implementation. I think that is something that we could look at.

Clement McDonald
Typically, it is buried in the data type, so if the data type is a codable data type, you have to have those other pieces, so you might be able to accommodate it that way without making separate elements.

Al Taylor
I think I understand what you mean, Clem. So, if it were just an alphanumeric string that starts with the letters "NPI," then that could possibly be a solution, or if it is a different codable system, you would have to identify that.

Clement McDonald
Well, that is a longer discussion. Maybe we can take it offline. But basically, if you just adopted what is in all the standards – whatever you are talking about, you define a data type – and that automatically specifies some of the sub-pieces that might be needed, or oral-optional. It applies to patient names and things like that too. Maybe I am getting off into the ether. Let me not keep going.

Steven Lane
Okay. So, we have cleared the raised hands, we have spent the bulk of our meeting focusing on this care team members data class, it sounds like we have come up with some pretty specific suggestions about adding the care team member role, bringing that from Level 2 into draft V.2, and clarifying that the provider ID would also entail sending the coding system and the version. Anything else on care team members?

Hans Buitendijk
Steven, this is Hans. On the coding system for the version, I think later on, as it is being refined, there will be comments back based on how that is being represented, but I just want to raise that that is not always being looked at as two separate concepts, but that is for later. Just a heads up.

Steven Lane
Okay, good. And then, there were some useful comments from Kelly, Leslie, and others about the fact that patient apps are obviously looking to pull this data from EHRs and other systems, and they are also not certified, so again, the standards need to be clear. All right. We are still about 15 minutes away from public comment. I do want to remind members of the public how much we appreciate your comments, and if you want to get any thoughts together in anticipation of that, you will be most welcome. If I may, I also want to turn to Sasha to ask the same question that I tried to ask of Hans, which is from a vender perspective, how challenging will it be to add these elements, including the additional ones that we have been discussing and perhaps will be formally suggesting.

Sasha TerMaat

Thanks, Steven. So, it is a good question, and I am glad that we are thinking about the lift that would be involved across the industry. From the perspective of the systems developers, I agree with Hans's take earlier that the overlap with some of these data elements with existing standards that are already supported by many systems or that are part of USCDI Version 1 and are sort of on the roadmap for systems will mean that it is a reasonable lift and we can expect a fairly continuous implementation of USCDI Version 2 on top of USCDI Version 1. We have, for example, alignment with some of the quality reporting concepts around encounters, and we have the existing notions of providers, as Hans mentioned, within US Core, though I do think it is important for us to be clear – to some of the earlier conversation – about what we mean when we discuss these items because that lack of clarity or late-breaking clarification can certainly put a roadblock in the development and implementation process.

Steven Lane
Thank you, and I think that point about insufficient detail, lack of clarity – hopefully, folks will feel comfortable adding comments to that effect down at the individual data element level because I think that is where we need it. So, again, I am looking at provider identifier. There are no comments entered on that page, so I think anybody who wants to go in – and, I really appreciate people – it is fine to comment ahead of our discussions. If you want to inform the discussion, that is the way that Dan, Mark, and others have done. It is also fine to wait until we have our discussion and toss in comments at that point if you feel like you have your ideas well formulated.

All right. So, at the risk of breaking things up a little, I would like to at least start the discussion of encounter information, realizing that we will only scratch the surface, and we will come back to that fully ready to go next week. There was a comment that this information – thank you, Sasha – aligns with quality reporting issues, and I know that Michelle, you have a real interest in supporting that alignment. Michelle, maybe you can start us off on the discussion of encounter information, both the value of the addition of encounter type, diagnosis, and time, as well as any challenges you see with those or key elements that might be missing.

Michelle Schreiber
Thank you for that, I appreciate it. So, encounter type, diagnosis, and time are important so that we can identify many of our quality measures. A few things that are not here that are also supportive of at least our ECQMs are encounter disposition. So, for example, if you are seen in the emergency department, what happens to you? Where do you go? Encounter location – that gets back to the organization ID, but encounter location, and also, the associated time period. So, we sort of had time, but I do not know that it captures the entire time period. So, those are things that are currently used in quality measures that are not on here, but encounter information really becomes the way that you obviously describe an encounter, and it is not as simple as it sounds. An admission is not an admission is not an admission.

Steven Lane
And again, when you look at the website and you look at the encounter information, we do have these three under Version 2. Under Level 2, we do have location and disposition, as you mentioned, so they were proposed and leveled, but not in the draft. Here again, we will have a similar conversation that we had with regard to the care team members, which is to say was that an oversight or a mistake? Should we be pushing to pull location and disposition from Level 2 up into draft V.2? At the comment level, there is the associated time period, as you mentioned, as well as encounter subject, status, participant time period, participant, and identifier – so, a lot of detail around the encounters got into each of the levels – not Level 1, interestingly

– but again, I think that part of our opportunity here really is to identify items that are leveled in Level 2 that were not included in draft V.2 and, as appropriate, make arguments that they should be brought forward. Dan, I know you also commented about time period in some of your remarks. Do you want to add anything here?

Daniel Vreeman
Yeah, thanks. I do want to speak in favor of including this encounter information. I think it is a welcome addition and hugely valuable for many purposes. Specifically around time, I was not clear on the data element definition of encounter time. Reading through the narrative text there, it sort of suggests a mix of possible data types – just a date, a start and end time stamp, perhaps a duration or period – and so, as a general rule, I think it is nice to be able to identify the intended data type for these data elements to help clarify these questions, and as Michelle just noted, there is a lot of complexity, and it was not clear to me what exactly was the intent, whether we are just talking about, say, a visit time for outpatient or these more complicated structures, such as you see in post-acute care where, for sure, the periods are important. So, that was my main comment.

Steven Lane
Thanks. Clem, your hand is up.

Clement McDonald
Yeah. This is both complicated and easy. Nothing has been standardized – I think for 40 years, there have been standard ways you report encounters for billing, and there are a lot more fields that I think are universal in the environment, and I do not know why we are being stingy in USCDI when these things are already out and about. So, I think we should look at the standards, take either V.2 or FHIR, and enlarge it to ones that the industry is using consistently everywhere, and then we do not have to argue about how to do it. It is done. You may want to tweak it, but then you go back to the standards. I think it is almost silly to dabble around the edges when this is something that is so well established. If you have a diagnosis, it has to be ICT-10. Now, the encounter time, as Dan said, needs some specification because it could be thought to be the time in the ER, but it is actually – and, typically in this standard, it is just a date, or it could be a date range, or a date/time range. So, some of these things need specification, but we should not start from scratch, and we should not be so stingy.

Steven Lane
Thank you. I will point out that encounter time in particular – when you look on the website – did engender one public comment from somebody named Janice. I do not think we have a Janice on our call today. We might. But, this is a good example of a question that came from the public trying to seek clarification on this. So, again, I suggested – I think Michelle did as well – that encounter disposition and location, which found their way into Level 2, might be appropriate to bring forward to draft V.2 – or, to V.2, I should say – and I think that speaks to Clem's point. If they are well established in our community and people are using them already, why would we be stingy? I like that word. Again, back to our vendor representatives, any concerns about the practicality of expanding V.2 to include location and disposition from Level 2? Maybe Sasha first?

Sasha TerMaat
Would those make sense in all contexts? I guess I am trying to think if you have a disposition for ambulatory offices, for example.

Steven Lane
Yeah, we would have to figure out what that means, right? I know when I do ambulatory office visits, sometimes I will say to follow up, sometimes I will refer, but there is not something that says "disposition" the way there may be in an acute care visit, but again, it comes back to this notion that if you collect it, then you must provide access, exchange, and use, but if you do not collect it, does USCDI say that you must collect it? That is a question that I think we still need a really ironclad answer on.

Sasha TerMaat
I think in many of these cases, I might want us to come to consensus on what we mean first before we assess the difficulty. In a hospital sense, I guess, the disposition might be quite established. I do not have a sense of what that would mean in an ambulatory visit, and depending on what we decided, it might have a varying implication for how ready it was to standardize that. I actually feel the same way about encounter time, too. Hospital visits are measured precisely from admission to discharge, and even there, there is often a lot of complexity around the timing in the emergency department and so forth. That does not usually exist on the ambulatory side, and getting to the same level of precision around exactly how long a visit lasts is not necessarily achievable in the same way for an office visit, so I think we would want to keep that in mind as we assess these. They might have varying implications depending on the domain.

Steven Lane
Hans, do you have anything to add to that?

Hans Buitendijk
Yes, and just picking up one point on the disposition that Sasha indicated, if you look at where US Core is heading – the next version currently being worked on – disposition would be under hospitalization, not necessarily other encounters, so it would be part of that conversation to make the clarification on the scope of it. There is another comment I want to make, and then I will put my EHRA hat on for a moment. As part of conversations there – and, again, in progress – the notion of an encounter – do all systems have that? There are many systems that do because of the way they operate, but in certain settings, that may not be totally in play in the way that we are thinking about it here and in a number of the interoperability standards.

So, to the question from an uptake perspective, there will be systems where this is very natural to do, and there will also be systems where, depending on how it works out between encounter and procedure information, they may have some more work to do where we do not understand exactly what that is and what the expectations are. So, just as context, the concept of an encounter may not be as totally widespread as one would think, although quite a few systems do have the concept of an encounter and have been working with that for a long period of time. This is a little bit of the balancing act that we are trying to understand a little bit better.

Steven Lane
I think that Grace and Leslie are contributing here, and Shelly Spiro as well. When you get outside of the hospital and the doctor's office – and, encounters really do have different meanings. Is it the face-to-face time? Is it the scheduled time? Is it the time that the provider actually came in when she was running late from delivering a baby? And, of course, when you are thinking about homecare, when you are thinking about ongoing supportive care or community care, there is not necessarily the same concept of an

encounter. Having said that, I think we all agree – back to Michelle's comments – that this is important stuff, that it is key to quality measures, that if systems do collect it already, as Clem pointed out, we should not be stingy in adding it to USCDI. So, that is a good start to that discussion. Everybody please feel free to bring additional ideas next week and to add your comments at the bottom of the individual data class and element pages if you see fit. It is time for public comment, and we would like to open that up.

Public Comment (01:23:40)

Michael Berry
All right. Operator, would you mind opening up the public comment, please?

Operator
Yes. If you would like to make a comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to take your line out of the queue, and for participants using speaker equipment, it may be necessary to pick up your handset before pressing *. One moment while we poll for comments. There are no comments at this time.

TF Schedule/Next Meeting (01:24:21)

Steven Lane
Okay, thank you so much. Thank you again to members of the public who have joined us and have been paying attention, and again, we do not want you to be stingy with your public comments. It is going to be our word of the day here. With four minutes remaining, I am not sure how much further we are going to get on the encounter information topic. Does anybody have anything else they want to share in that regard? All right. But again, I would like to dive a little bit deeper into that next time, and it seems like we might have exhausted ourselves in large part on that one, so we will also be prepared to discuss problems. In the same way that Al was the submitter for the care team data elements, in full transparency, I will note that I was the submitter for the date of diagnosis and date of resolution, so I will try not to be any more defensive than Al was in talking about those next week.

We are scheduled to meet at the same time, same station next week. I hope that the weather is such that we have more people able to participate. Again, do make sure that you have access to the website so you can insert comments and make sure that you have access to the Google Drive so that you can participate there. I and the ONC team will endeavor to finish off our notes from last week as well as this week and try to get those posted as soon as possible. I would love to see those posted by the end of the week so people have a chance to look at them over the weekend.

Any other thoughts – any process comments or things that we should be doing differently or could be doing better in future meetings? If you think of them subsequently, feel free to forward them along, either privately or to the larger group. Again, thank you, Grace, for joining us, for gracing us with your presence, and I do not mind ending 90 seconds early. I hope everybody stays well, and we will try to get materials out to you. Hans and Ricky, thanks for taking assignment. I know that was a little rash on my part. I am happy to help facilitate that over the coming week. Everybody have a great day.

Hans Buitendijk
Thanks so much. Bye.

Leslie Kelly Hall
Bye, thank you.

Adjourn (01:27:06)